



J-1 VISA WAIVER PROGRAM
Request For Letter of Support
PHYSICIAN APPLICATION

PROGRAM APPLYING FOR:
(SELECT ONE ONLY)

☐

PRIMARY CARE

☐

SPECIALTY

NAME

(Last)

(First)

(Middle Initial)

(DOS Case Number)

LANGUAGES SPOKEN FLUENTLY:

CURRENT MAILING ADDRESS

(Street Address)

(Apt Number)

(City)

(State)

(Zip)

PHONE NUMBER: Home: ()

Other: ()

E-Mail:

SERVICE SITE: (NAME)

PHYSICAL ADDRESS

(Street Address)

(City)

(State)

(Zip)

MAILING ADDRESS (if different from street address)

(City)

(State)

(Zip)

EMPLOYER (If different from the service site):

CONTACT PERSON:

MAILING ADDRESS:

(City)

(State)

(Zip)

PHONE NUMBERS:

Main

Fax

E-Mail:

SERVICE DATES (anticipated)

MM/DD/YY

TO

MM/DD/YY

OFFICE USE ONLY

PROGRAM EXPECTATIONS FOR THE J-1 PHYSICIAN

THE J-1 PHYSICIAN UNDERSTANDS AND AGREES TO:

1. Provide primary care services (family or general practice, pediatrics, internal medicine or obstetrics/gynecology), psychiatry, or the approved specialty services on a full-time basis (at least 40 hours per week) for at least 3 years in a Health Professional Shortage Area (HPSA) or federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP) at the approved location for which the J-1 visa waiver is issued.
2. Notify the Arizona Department of Health Services before transferring to another location.
3. Be an AHCCCS (AZ Medicaid) and Medicare registered provider, and accept AHCCCS and Medicare assignment. Accept all patients regardless of method of payment or ability to pay and provide services to those who have no health insurance coverage, will charge patients at the usual and prevailing rates in this area, and will have a sliding-discount-to-fee scale based on ability to pay. The scale will be based on the current Department of Health and Human Services Poverty Guidelines as published in the Federal Register.
4. Submit a quarterly report of the number of persons seen on a Encounter form to be provided by the Department. Of those encounters, the number of persons using the sliding-discount-to-fee scale will be reported.
5. Commence practice within 90 days of issuance of the waiver by the Bureau of Citizenship and Immigration Services (BCIS; formerly INS) and submit to the Department a copy of BCIS' approval notice,

THE J-1 PHYSICIAN UNDERSTANDS THAT:

1. The review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the Department, any and all employees, agents and assigns from any action or lack of action made in connection with this request.
2. The entire basis for the consideration of my request is the voluntary policy of the Department and its desire to improve the availability of medical care in regions designated by the United States Public Health Services as health professional shortage areas or medically underserved areas or populations.
3. Any employment agreement I enter pursuant to paragraph A.1. shall not contain any provision which modifies or amends any of the terms of the program's expectations
4. My services rendered pursuant to paragraph A.1. shall be in a Medicare certified facility which has an open, non-discriminatory admission policy and that will accept AHCCCS, Medicare/Medicaid and SCHIP assignments.